Directors (AFMRD), which provides a number of resources to program leadership, such as the PD Toolbox and Resource Library, in addition to an active, collaborative online community where members can pose questions and benefit from the expertise of fellow program directors across the country. Directors of osteopathic education may use the American Osteopathic Board of Family Physicians website as a resource for designated osteopathic residents desiring AOA board certification in Family Medicine.

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Sarah Z. Cole, DO, FAAFP and Karen Elisa Milian Olmos, MD, MPH

AAFP From the American Academy of Family Physicians

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FROM AAFP: AAFP ADVANCES ON LONG-TERM CLINICAL RECOMMENDATION PROJECT

The AAFP has taken the next steps toward a project designed to make it easier for family physicians to access, review, and share the clinical guidelines and related information that help them give patients optimal care, in resources available at https://www.aafp.org/family-physician/patient-care/clinical-recommendations.html.

After launching the project with development of a chronic obstructive pulmonary disease (COPD) clinical guidance webpage, the Academy recently published a new clinical guidance page on diabetes that lets members find clinical recommendations, implementation tools, quality measures, and educational materials for physicians in 1 location.

Diabetes: Clinical Guidance and Practice Resources at a Glance

The new clinical guidance page organizes information into several categories.

- **Screening Recommendations** contains a link to the updated AAFP clinical preventive service recommendations
- **Treatment and Management Recommendations** features links to AAFP-endorsed or supported guidance on oral pharmacologic treatment and the care of people who have or are at risk of having diabetes
- **Managing Your Practice** gives members an assortment of tools and resources to better coordinate and improve patient care
- **Implementation Tools and Considerations** links to a report on diabetes self-management education and support co-authored by the Academy and 6 other medical organizations, as well as links to 3 AAFP TIPS activities
- **Education** provides CME resources for clinicians, links to articles on diabetes and a series of patient education materials on familydoctor.org
- **Other Related Resources** directs members to the Academy's Prevention and Wellness: Healthy Lifestyle webpage, which features information on nutrition and physical activity, oral health and related topics

The highlight of the page is "Diabetes Screening for Adults," an updated clinical recommendation developed by the AAFP and approved in November 2021.

The AAFP's recommendation is based on a final recommendation statement on screening for prediabetes and type 2 diabetes published by the US Preventive Services Task Force in August 2021.

It should be noted that the AAFP's recommendation differs from the task force's recommendation statement in some areas.

The USPSTF recommends screening for prediabetes and type 2 diabetes in adults aged 35 to 70 years who have overweight or obesity, and also recommends that clinicians offer or refer patients with prediabetes to effective preventive interventions. In contrast, the AAFP has concluded that the evidence is insufficient to assess the benefits and harms of screening for type 2 diabetes in adults aged 35 to 39 years. The AAFP stated in its recommendation that most of the evidence presented in the task force's evidence report looked at adults over age 40, and that there were no subgroup analyses that specifically examined screening at younger ages.

Moreover, the AAFP does not agree that there is evidence to support screening for prediabetes. In its recommendation, the AAFP stated that "the current evidence does not show improvement in long-term health outcomes for screening for prediabetes in adults who have obesity or overweight," and that since screening for prediabetes is neither sensitive nor specific, it may result in false positives or false negatives.

Sarah Coles, MD, chair of the Academy's Commission on Health of the Public and Science and an assistant professor in the Department of Family, Community and Preventive Medicine at the University of Arizona College of Medicine–Phoenix Family Medicine Residency, told *AAFP News* why the Academy's stance differed from that of the task force.

"The AAFP agrees with screening for diabetes in adults ages 40 to 70 who have obesity or are overweight and screening pregnant persons for gestational diabetes at 24 weeks gestation or greater," said Coles. "After careful review of the USPSTF evidence report, the AAFP disagreed with the USPSTF on a few key points.

The AAFP felt that there is currently insufficient evidence to recommend screening adults who are 35 to 39 years old. There was very little data about individuals in this age group. Unlike people who are diagnosed with diabetes when presenting with symptoms, people who had screen-detected diabetes did not show improvements in important patient-oriented health outcomes, like mortality or cardiovascular events.

The AAFP also does not agree that there is sufficient evidence to recommend screening for prediabetes," Coles continued. "The best available evidence does not show any long-term health outcomes from screening and the harms have not been adequately studied. Stigma and labeling have the potential to worsen health outcomes."

Recommendations for screening for gestational diabetes in individuals who are pregnant are also included in the update. The Academy supports the task force's recommendations on screening in this population.

More Pages Coming Soon

The new diabetes clinical guidance page is part of a long-term project to renovate the Clinical Recommendations section of AAFP.org. Additional clinical guidance pages are currently in development; when finalized, they will integrate clinical, implementation, and education guidance to ensure standardized care for a number of specific conditions commonly seen in family medicine practices.

Members are welcome to provide feedback on the new pages or suggest other topics for guidance by e-mailing clinicalpolicies@aafp.org. Members also are encouraged to bookmark the Clinical Recommendations index page to find the latest updates, and to visit *AAFP News* for more information as it becomes available.

News Staff
AAFP News

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HIGH-STAKES KNOWLEDGE ASSESSMENT AT ABFM: WHAT WE HAVE LEARNED AND HOW IT IS USEFUL

Clinical knowledge is fundamental to the social contract between medicine and society. As 1 of the 6 core competencies, appropriate clinical knowledge is effortfully acquired, constantly updated through practice and learning, and regularly assessed independently through board certification—and patients care **a lot** about it.

It is thus important for ABFM to regularly review the validity of ABFM high-stakes knowledge assessments. In comparison with other common assessments of clinical knowledge—the ward attending who sees the medical student on rounds and asks some questions, patient satisfaction surveys, a medical school specialty advisor who writes a letter of recommendation—a well-constructed multiple-choice exam potentially provides a more standardized approach, greater reliability and scalability, and much less expense. In an age of increased understanding of structural racism, however, it is important to ask whether board certification exams are biased against certain racial and ethnic groups. In recent years, many standardized tests have been accused of bias.[1,2]

In this context, the recent report of O'Neill et al provides important information.[3] ABFM began to collect data on race and ethnicity of its Diplomates in 2013 in order to assess its high-stakes multiple-choice questions for bias. Differential Item Functioning (DIF) is the industry standard approach to questions for bias.[4,5] Briefly, DIF analysis screens multiple-choice questions for differential impact across racial and ethnic groups, controlling for the ability of the test-taker. Any items that are identified by this statistical screening process are then reviewed by a panel of physicians of underrepresented race and ethnicity groups, who are charged to assess whether the underlying clinical concept is appropriate for family physicians. This report summarizes 8 years of DIF testing. The data suggest that about 11% of our questions show a degree of differential performance across groups, but overall, there was no significant advantage to one group over another. Furthermore, close review by the DIF panel concluded that only 0.1% the questions had an identifiable source of bias that was not an important aspect of family medicine. So, after 8 years, we have determined that there are some questions we will not use going forward, but it is a very modest number. A similar report was published in *Academic Medicine* about the United States Licensing Medical Examination Part I by the National Board of Medical Examiners.[6] Modern national psychometric tests at the Licensure and Board certification level seem to have minimized bias of individual questions against major racial and ethnic groups. Given the importance of testing to health equity, ABFM will continue to monitor its questions for bias.

Furthermore, valid knowledge assessments can help track trends in education. Driven by ABFM's commitment to improving health equity, ABFM has begun to look at trajectories of knowledge acquisition by race and ethnicity among family medicine residents. Wang et al publish their results this month in *Family Medicine*.[7] Importantly, the In-Training Exam is set on the same psychometric scale as the ABFM Certification Exam, making it possible to characterize the trajectory of knowledge acquisition across the 3 years of residency training up to and including initial certification examination. Figure 1 illustrates their findings. Their analysis has 3 important findings: first, different racial and ethnic groups start residency at different levels of mean scores on the exam. ABFM believes that the magnitude of these differences is meaningful. Given